STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335457	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiddlers Green Manor Rehab and Nursing Center	168 West Main Street Springville, NY 14141

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review completed during the survey, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food safety for one (1) of one (1) kitchen. Specifically, on multiple observations, the kitchen ceiling had an active leak along the exhaust hood, onto the front of the stove top, behind the stove, and to the right of the stove, onto the floor. The entire kitchen ceiling was in disrepair, sagging in multiple places, had mixed textures and materials covering the surface, with visible stains and food splatter. The kitchen walls had visible water damage and multiple textures of plaster. Additionally, there were multiple observations of an active leak into an open container under the three (3) bay sink. The findings are:The policy titled Kitchen Operations Sanitization dated October 2008, documented the food service area shall be maintained in a clean and sanitary manner. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.The policy titled Physical Environment, Work Orders, Maintenance, dated April 2010, documented in order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director.During an observation and interview in the kitchen, on 01/27/2026 at 10:25 AM, there was an area of visible water damage on the plaster ceiling approximately three (3) feet in diameter, left of center, as viewed upon entering the room. There was also a ceiling patch made of wood paneling approximately 18 inches by 24 inches to the left of the exhaust hood. There were ceiling patch panels along the front of the exhaust hood that were sagging and ceiling patch panels to the right of the exhaust hood that were sagging. In the kitchen's left ceiling corner, there was an area of water damage that was sagging on the plaster ceiling, approximately one (1) foot in diameter. The plaster archway between the kitchen and the dishwash area had visible water damage on the top and sides, which spanned approximately three (3) feet wide. The Director of Environmental Services stated the ceiling water damage was caused by a previous leak from the shower room above. Continued observation revealed an active leak beneath the three (3) bay sink. The lower half of the wall behind the sink was saturated, and a bin on the floor beneath the sink had collected at least one (1) inch of water. The Director of Environmental Services stated they were aware of the leak and thought they had fixed it the day before.During an interview on 01/27/2026 at 11:46 AM, [NAME] #1 stated they worked in the facility for over 30 years and through that time the ceiling in the kitchen had leaked several times. They stated the most recent leak happened approximately two (2) weeks ago. [NAME] #1 stated if they saw the leak they would call maintenance and they would come fix it. They stated it was not sanitary to have a leaking ceiling in the kitchen. [NAME] #1 stated the container under the sink needed to be emptied daily; they were unsure how long that had been going on.During an interview on 01/28/2026 at 2:34 PM, the Food Service Director stated the last time there was a visible water leak was about a week and a half ago. They stated they did not know exactly what caused the leak but had heard it might be from the shower room above or possibly from the hood vent outside. Maintenance had repaired the ceiling, but they did not know of a plan to replace the ceiling. The Food Service Director stated they attempted to clean the ceiling a while ago, but they were unable to get it clean. They stated the possibility of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shower water leaking into the kitchen was gross, and the multiple surfaces made it impossible to properly clean the ceiling. They stated the water leaking from the sink was continuous, they had to empty the container about every other day. They stated having a bucket of standing water in the kitchen was not sanitary and could be an infection control risk.During an observation and interview in the kitchen on 01/29/2026 at 11:58 AM, there was visible water dripping along the outside front, back and sides of the exhaust hood. There were three (3) visible dripping water marks on the front of the hood stretching from the top to the bottom edge. The drip on the front was landing in a metal pan, on the front burner of the stove, with a white towel placed inside. The back drip was creating a puddle on the floor towards the left of the stove; the right-side drip was creating a large puddle on the floor where a towel had been placed. The Food Service Director stated they had never seen it drip that much, that fast. They left to find the Director of Environmental Services.During an observation and interview in the kitchen on 01/29/2026 at 12:07 PM, the Director of Environmental Services observed the active leak. They stated they had never seen it leak that actively before. They stated it was not appropriate to have an active leak in the kitchen, and they would immediately go upstairs to try and find the source.During an interview on 01/29/2026 at 2:45 PM, the Director of Environmental Services stated approximately two (2) to three (3) months ago, they valved off stall #2 in the first-floor shower room, which had leaked into the kitchen below and that remained out of service. It then leaked again into the kitchen about 2 weeks ago. They stated when they saw the leak in the kitchen this afternoon, they were unable to locate the source of the leak.During an observation and interview in the kitchen on 01/30/2026 at 8:50 AM, there was an active drip to the right side of the exhaust hood. The Food Service Director stated it had dripped on and off throughout the morning, causing a puddle that was collected in a towel.During an observation and interview in the kitchen on 01/30/2026 at 9:51 AM, the Administrator stated they were aware there was a leak in the kitchen but did not know it was actively leaking. They observed the dripping from the hood and the water marks along the outside of the hood. They did not know how long it had been going on. They heard maintenance was looking at the shower room above, as the cause. They stated it was gross if shower water was leaking into the kitchen. They were unable to say whether the ceiling could be properly sanitized, but there was definitely work to be done on the ceiling in the kitchen.During an observation and interview on 02/02/2026 8:21 AM, there was an active drip from the right side of the exhaust hood, dripping onto a towel on the floor, and a slower drip to the left/back side of the hood. [NAME] #1 stated the water had been dripping since they got there that day.During an interview on 02/02/2026 at 10:03 AM, Registered Nurse #1, the Infection Preventionist, stated it was unsanitary to have a leak in the kitchen, especially if it was coming from a shower room. They stated the multi-textured, patched ceiling would be difficult to properly sanitize.During an interview on 02/02/2026 at 10:44 AM, the Director of Environmental Services stated they did not have a log for when the kitchen had a leak. Kitchen staff verbally called them when there was an issue. They stated the facility needed to call a plumber to figure out where the water was coming from.During an interview on 02/02/2026 at 10:54 AM, the Administrator stated there should have been a logbook of the maintenance issues in the kitchen. They stated they planned to bring in a plumber to find out what the issue was and fix it.10 NYCRR 415.14 (h)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility did not implement written policies and procedures for screening employees that would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, the facility had no evidence that verified six (6) (Certified Nurse Aide #1, Certified Nurse Aide #2, Licensed Practical Nurse #1, Dietary Aide #1, Administration/ Receptionist #1, and Nurse Aide Trainee/ Unit Helper #1) of eight (8) employees reviewed that worked in the facility and were subject to the New York State Nurse Aide Registry had been screened through the New York State Nurse Aide Registry prior to their first date worked at the facility.The findings are: The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised November 2025, documented the resident abuse, neglect and exploitation prevention program consisted of a facility-wide commitment and resource allocation to support its objectives. The objectives included developing and implementing policies and protocols to prevent and identify abuse or mistreatment of residents, neglect of residents, and/ or theft, exploitation, or misappropriation of resident property. The facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The policy and procedure titled Background Screening Investigations, revised November 2015, documented for any individual applying for a position as a Certified Nursing Assistant, the state nurse aide registry will be contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/ or theft of property have been entered into the applicant's file. For any licensed professional applying for a position that may involve direct contact with residents, his/her respective licensing board will be contacted to determine if any sanctions have been assessed against the applicant's license. 1a. Review of Certified Nurse Aide #1's personnel file revealed it contained no documented evidence that a New York State Nurse Aide Registry check was completed for Certified Nurse Aide #1, who worked at the facility from 01/08/2025 to 01/22/2025 and 04/24/2025 to 5/16/2025. 1b. Review of Certified Nurse Aide #2's personnel file on 01/29/2026 revealed it contained a New York State Nurse Aide Registry verification sheet that was dated 01/28/2026. Certified Nurse Aide #1 was a current Certified Nurse Aide at the facility who started employment on 11/04/2025. 1c. Review of Licensed Practical Nurse #1's personnel file on 01/29/2026 revealed it contained a New York State Nurse Aide Registry verification sheet that was dated 01/28/2026. Licensed Practical Nurse #1 was a current Licensed Practical Nurse at the facility who started employment on 12/02/2025. 1d. Review of Dietary Aide #1's personnel file revealed it contained no documentation that a New York State Nurse Aide Registry check was performed for Dietary Aide #1, who currently worked at the facility and started employment on 09/30/2025. 1e. Review of Administration/ Receptionist #1's personnel file 01/29/2026 revealed it contained a New York State Nurse Aide Registry verification sheet that was dated 01/28/2026. Administration/ Receptionist #1 worked at this facility from 10/29/2025 to 01/23/2026. 1f. Review of Nurse Aide Trainee/ Unit Helper #1's personnel file revealed it contained no documented evidence that a New York State Nurse Aide Registry check was completed for Nurse Aide Trainee/ Unit Helper #1, who worked at this facility from 01/29/2025 to 03/07/2025. During an interview on 01/29/2026 at 9:24 AM, the Staffing and Payroll Coordinator stated they had been the Staffing and Payroll Coordinator at this facility since March 2025. They stated their procedure included checking the Nurse Aide Registry for each new hire and placing the verification sheet in the personnel file. They stated they performed an audit a few months ago to ensure Nurse Aide Registry check verification sheets were in all personnel files. During the audit, they found a few were missing and made corrections at that time. The Staffing and Payroll Coordinator also stated on 01/28/2026, they pulled all personnel files from staff hired in the last four (4) months to prepare for the survey and to make sure everything was in order. They stated they noticed a few more Nurse Aide Registry (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	check verification sheets were missing and made corrections at that time. During an interview on 01/29/2026 at 1:35 PM, the Director of Nursing stated a check of the Nurse Aide Registry was a part of the facility's background check process that should occur upon hire. During an interview on 01/30/2026 at 12:10 PM, the Administrator stated the Staffing and Payroll Coordinator was responsible to look up all new hires in the New York State Nurse Aide Registry and print the result sheet. The Administrator stated this was done for all new employees upon hire. The Administrator also stated they had completed spot checks of personnel files for Nurse Aide Registry verification sheets, and they found no issues during their spot checks. 10 NYCRR 415.4(b)(1)(ii)(a)(b)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review conducted during the survey, the facility did not ensure residents have the right to personal privacy including accommodations for one (1) (Resident #3) of one (1) resident reviewed. Specifically, a privacy curtain in the resident's room did not fully enclose Resident #3's bed. The finding is:The policy titled Resident Rights Guidelines for Nursing Procedures dated October 2010 documented prior to having direct care responsibilities for residents, staff must have appropriate in-service training on resident rights including resident dignity and respect.The policy titled Bedrooms dated May 2017 documented each room was designed to provide full visual privacy for each resident (in the form of ceiling-suspended curtains that extend around the bed) and equipped for adequate nursing care.Resident #3 had diagnoses which included depression, anxiety, and fracture of the left lower leg. The Minimum Data Set (a resident assessment tool) dated 01/03/2026 documented the resident was understood, understands and was cognitively intact.Review of comprehensive care plan revised on 12/30/2026 documented Resident #3 had an activity of daily living self-care performance deficit related to weakness. Interventions included toilet use: total assistance with bedpan and ostomy (artificial connection of the bowel to the skin surface) care.Review of the maintenance logbook located at the nurses' station on 02/02/2026 at 9:10 AM revealed between 12/16/2025 through 02/02/2026 there was no documented evidence that staff notified maintenance of the privacy curtain not going around Resident #3's bed.During an interview on 01/27/2026 at 1:10 PM, Resident #3 stated they felt they did not have any privacy in their room because their roommate would get up and use the bathroom frequently. They stated their roommate would also look around the curtain whenever the nurse was changing their ostomy (artificial connection of the bowel to the skin surface).During an observation and interview on 01/29/2026 at 8:43 AM, Resident #3 was lying in bed. The bathroom door was located near the head of their bed with the privacy curatin between Resident #3's bed and the door. The privacy curtain wrapped approximately halfway around the bed when it was fully pulled closed. Resident #3 stated that the staff closed the curtain, but it does not go all the way around their bed. They stated there were times their roommate would walk past their bed, on their way to the bathroom, and then the roommate would look over and be able to see any care that was being provided.During an interview on 01/30/2026 at 1:31 PM, Certified Nurse Aide #4 stated there were curtains on the unit that do not fully go around the bed of the resident. They stated for Resident #3 they pull the curtain around the foot of the bed and that way only the head of the bed would be exposed. They stated they felt they were still providing privacy to Resident #3, but there could be a privacy problem if the roommate got up to use the bathroom because they would be able to look around the curtain by the head of the bed.During an interview on 01/30/2026 at 3:04 PM, Certified Nurse Aide #5 stated some curtains on the unit did not close all the way and they just did not seem long enough. They stated they did not see it as a privacy concern because they would shut the door or close the curtain of the roommate as well. They stated if one of the roommates wanted to leave or enter the room, they would just have to wait a minute or so until they covered up the resident that they were providing care to.During an observation and interview on 02/02/2026 at 08:57 AM, Licensed Practical Nurse #2 pulled the privacy curtain around Resident #3's former bed. There was a gap between the end of the curtain and the wall. Licensed Practical Nurse #2 stated that there appeared to be a four (4) foot gap between the end of the curtain and the wall and it should not have been like that. They stated that there would be a privacy problem. They stated that the curtain not wrapping around the entire bed should have been entered into the maintenance logbook by anyone who had known it was not wrapping around the bed. During an observation and interview on 02/02/2026 at 9:02 AM Registered Nurse #1 Unit Manager stated Resident #3 had moved to a different bed so the staff could keep a better eye on them. They observed Resident #3's prior room and stated there was a large gap between the end of the privacy curtain and the wall of Resident #3's previous bed. They stated there should not have been a gap that (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	large because it could be a dignity or privacy problem for the resident using that bed. They stated if another resident wanted to either enter or leave the room, they would probably have to wait until care was completed on the resident in that bed. They stated that residents should not have to wait to enter or leave their own room. During an interview on 02/02/2026 at 9:30 AM The Director of Environmental Services stated they were responsible for ensuring the privacy curtains went completely around the beds in the resident rooms. They stated the privacy curtain should have completely enveloped the bed because otherwise it would be a dignity concern.During an interview on 02/02/2026 at 9:41 AM The Director of Nursing stated the privacy curtain should have gone all the way around Resident #3's bed. They stated there should not have been any gaps anywhere for privacy reasons. They stated the certified nurse aides who were aware should have reported the concern to maintenance.During an interview on 02/02/2026 at 10:42 AM, the Administrator stated the privacy curtain should have fully enclosed the bed. They stated not all the privacy curtains were the same length and the correct length depended on where the privacy curtain was being hung. They stated they were unsure how the shorter curtain was hung around Resident #6's bed or for how long it was hung there. They stated it was unknown who had taken it down or who hung up the curtain. It could have been someone from housekeeping who was washing the curtain, or it could have been someone in maintenance. They stated ultimately the Director of Environmental Services was responsible for making sure the correct privacy curtains were hung. They stated the certified nurse aides who were aware that the curtain was too short should have made someone aware and it should have been placed in the maintenance logbook.10 NYCRR 415.3(e)